		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043968

Facility Name: ASTA CARE CENTER OF PONTIAC

Address: 300 WEST LOWELL (Number) PONTIAC (City) 61764 (Zip Code)

County: LIVINGSTON

Telephone Number: (847) 742-2288 **Fax #** (847) 742-9013

IDPA ID Number: 36-4228801

Date of Initial License for Current Owners: 08/17/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/16/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)	5	1,825	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	83	27,503	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	88	29,328	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,638	1,638	8
9	SNF/PED					9
10	ICF	16,148	9,399	729	26,276	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,148	9,399	2,367	27,914	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.18%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
DAY CARE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/17/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/17/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 5 and days of care provided 1,638

Medicare Intermediary ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	155,792	12,635	6,702	175,129		175,129		175,129			1
2	Food Purchase		112,801		112,801		112,801	(2,821)	109,980			2
3	Housekeeping	101,703	21,553		123,256		123,256		123,256			3
4	Laundry	55,152	14,721	586	70,459		70,459		70,459			4
5	Heat and Other Utilities			78,747	78,747		78,747		78,747			5
6	Maintenance	21,517	8,296	26,383	56,196		56,196	4,005	60,201			6
7	Other (specify):* Scavenger,Security			5,581	5,581		5,581		5,581			7
8	TOTAL General Services	334,164	170,006	117,999	622,169		622,169	1,184	623,353			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	825,833	53,907	154,277	1,034,017		1,034,017		1,034,017			10
10a	Therapy		248	650	898		898		898			10a
11	Activities	117,712	8,425	848	126,985		126,985		126,985			11
12	Social Services	31,004		2,002	33,006		33,006		33,006			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	974,549	62,580	163,277	1,200,406		1,200,406		1,200,406			16
	C. General Administration											
17	Administrative	59,991		205,842	265,833	(8,700)	257,133	(136,299)	120,834			17
18	Directors Fees											18
19	Professional Services			22,770	22,770	8,700	31,470	887	32,357			19
20	Dues, Fees, Subscriptions & Promotions			42,650	42,650		42,650	(25,013)	17,637			20
21	Clerical & General Office Expenses	75,359	15,603	26,723	117,685		117,685	12,964	130,649			21
22	Employee Benefits & Payroll Taxes			235,202	235,202		235,202		235,202			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,030	4,030		4,030	91	4,121			24
25	Other Admin. Staff Transportation			15,940	15,940		15,940	2,011	17,951			25
26	Insurance-Prop.Liab.Malpractice			58,687	58,687		58,687	1,638	60,325			26
27	Other (specify):* Bad Debts			12,886	12,886		12,886	(5,528)	7,358			27
28	TOTAL General Administration	135,350	15,603	624,730	775,683		775,683	(149,249)	626,434			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,444,063	248,189	906,006	2,598,258		2,598,258	(148,065)	2,450,193			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC #0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,492	18,492		18,492	130,893	149,385			30
31	Amortization of Pre-Op. & Org.			927	927		927		927			31
32	Interest			24,237	24,237		24,237	152,328	176,565			32
33	Real Estate Taxes			36,818	36,818		36,818		36,818			33
34	Rent-Facility & Grounds			205,185	205,185		205,185	(205,185)				34
35	Rent-Equipment & Vehicles			2,609	2,609		2,609	1,095	3,704			35
36	Other (specify):* amort-comp soft.			374	374		374	6,221	6,595			36
37	TOTAL Ownership			288,642	288,642		288,642	85,352	373,994			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,528	125,251	162,779		162,779		162,779			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,992	43,992		43,992		43,992			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		37,528	169,243	206,771		206,771		206,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,444,063	285,717	1,363,891	3,093,671		3,093,671	(62,713)	3,030,958			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	32,189	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(627)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,194)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,983)	21		18
19	Entertainment		20		19
20	Contributions	(1,721)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,886)	27		24
25	Fund Raising, Advertising and Promotional	(23,635)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(8,461)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,318)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(43,395)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (43,395)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (62,713)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ASTA CARE CENTER OF PONTIAC

ID# 0043968

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 4,005	6	1
2	MARKETING DIRECTOR SALARY	(8,805)	21	2
3	BANK CHARGES	(3,661)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,461)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,821)	0	0	0	0	0	0	0	0	0	0	(2,821)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,005	0	0	0	0	0	0	0	0	0	0	4,005	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,184	0	0	0	0	0	0	0	0	0	0	1,184	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(136,299)	0	0	0	0	0	0	0	0	0	(136,299)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	887	0	0	0	0	0	0	0	0	0	887	19
20	Fees, Subscriptions & Promotions	(25,356)	343	0	0	0	0	0	0	0	0	0	(25,013)	20
21	Clerical & General Office Expenses	(14,449)	27,413	0	0	0	0	0	0	0	0	0	12,964	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	91	0	0	0	0	0	0	0	0	0	91	24
25	Other Admin. Staff Transportation	0	2,011	0	0	0	0	0	0	0	0	0	2,011	25
26	Insurance-Prop.Liab.Malpractice	0	1,638	0	0	0	0	0	0	0	0	0	1,638	26
27	Other (specify):*	(12,886)	7,358	0	0	0	0	0	0	0	0	0	(5,528)	27
28	**TOTAL General Administration**	(52,691)	(96,558)	0	0	0	0	0	0	0	0	0	(149,249)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,507)	(96,558)	0	0	0	0	0	0	0	0	0	(148,065)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	32,189	0	98,704	0	0	0	0	0	0	0	0	130,893	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	957	151,371	0	0	0	0	0	0	0	0	152,328	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(205,185)	0	0	0	0	0	0	0	0	(205,185)	34
35	Rent-Equipment & Vehicles	0	1,095	0	0	0	0	0	0	0	0	0	1,095	35
36	Other (specify):*	0	0	6,221	0	0	0	0	0	0	0	0	6,221	36
37	**TOTAL Ownership**	32,189	2,052	51,111	0	0	0	0	0	0	0	0	85,352	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,318)	(94,506)	51,111	0	0	0	0	0	0	0	0	(62,713)	45

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MICHAEL GILLMAN	25	LIST ATTACHED		ASTA HEALTH-	ELGIN	MANAGEMENT
DARRYLE GILLMAN	25			CARE COMPANY		
BARRY KIRSCHEBAUM	25					
DIANR KIRSCHENBAUM	25			ASTA PONTIAC	ELGIN	REAL ESTATE
				PROPERTIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 182,142	ASTA HEALTH CARE COMPANY		$	$ (182,142)	1
2	V	17	OFFICER SALARIES				13,324	13,324	2
3	V	17	ADMINISTRATIVE SALARIES				32,519	32,519	3
4	V	19	PROFESSIONAL FEES				887	887	4
5	V	20	LICENSES & PERMITS				343	343	5
6	V	21	OFFICE EXPENSE				27,413	27,413	6
7	V	24	EDUCATION & SEMINARS				91	91	7
8	V	25	TRANSPORTATION				2,011	2,011	8
9	V	26	INSURANCE				1,638	1,638	9
10	V	27	PAYROLL TAXES,HEALTH IN				7,358	7,358	10
11	V	32	INTEREST EXPENSE				957	957	11
12	V	35	COPIER LEASE				613	613	12
13	V	35	AUTO LEASE				482	482	13
14	Total			$ 182,142			$ 87,636	$ * (94,506)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 205,185			$	$ (205,185)	15
16	V	30	DEPRECIATION		ASTA PONTIAC PROPERTIES		98,704	98,704	16
17	V	32	INTEREST		ASTA PONTIAC PROPERTIES		151,371	151,371	17
18	V	36	AMORT - MORT COSTS		ASTA PONTIAC PROPERTIES		6,221	6,221	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 205,185			$ 256,296	$ * 51,111	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3		SEE ATTACHED									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA HEALTHCARE COMPANY
Street Address: 134 N. MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARIES	PATIENT DAYS	167,599	6	$ 80,000	$ 80,000	27,914	$ 13,324	1
2	17	OFFICER SALARIES	DIRECT	2	2	80,000	80,000	0	0	2
3	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	167,599	6	195,246	195,246	27,914	32,519	3
4	17	ADMINISTRATIVE SALARIES	DIRECT	1	1	41,574	41,574	0	0	4
5	17	ADMINISTRATIVE SALARIES	DIRECT	1	1	112,600	112,600	0	0	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	167,599	6	5,324		27,914	887	6
7	20	LICENSES & PERMITS	PATIENT DAYS	167,599	6	2,062		27,914	343	7
8	21	OFFICE EXPENSE	PATIENT DAYS	167,599	6	164,588	128,291	27,914	27,413	8
9	24	EDUCATION & SEMINARS	PATIENT DAYS	167,599	6	545		27,914	91	9
10	25	TRANSPORTATION	PATIENT DAYS	167,599	6	12,073		27,914	2,011	10
11	26	INSURANCE	PATIENT DAYS	167,599	6	9,832		27,914	1,638	11
12	27	PAYROLL TAXES,HEALTH IN	PATIENT DAYS	167,599	6	44,177		27,914	7,358	12
13	32	INTEREST EXPENSE	PATIENT DAYS	167,599	6	5,745		27,914	957	13
14	35	COPIER LEASE	PATIENT DAYS	167,599	6	3,681		27,914	613	14
15	35	AUTO LEASE	PATIENT DAYS	167,599	6	2,893		27,914	482	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 760,340	$ 637,711		$ 87,636	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA PONTIAC ROPERTIES
Street Address: 134 N MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST	1	1	$ 98,704	$	1	$ 98,704	1
2	32	INTEREST	DIRECT COST	1	1	151,371		1	151,371	2
3	36	AMORT - DEFERRED MORT	DIRECT COST	1	1	6,221		1	6,221	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 256,296	$		$ 256,296	25

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	AMERICAN NATL BANK		X	MORTGAGE	$17,099.00	8/17/98	$ 2,075,000	$ 1,868,593	8/17/03	0.0780	$ 150,155	1
2											1,216	2
3												3
4	RELATED PARTY-ASTA										957	4
5	ASTA MANAGEMENT										5,667	5
	Working Capital											
6	AMERICAN NATL BANK		X	WORKING CAPITAL	INTEREST	REVOLV	150,000	238,000	REVOLV	PRIME+	14,803	6
7	CAPITAL ALLIANCE		X	VAN PURCHASE	$831.00	05/15/99	31,200			0.1133	2,358	7
8	A.I.CREDIT CORP		X	INSURANCE POLICIES							1,409	8
9	TOTAL Facility Related				$17,930.00		$ 2,256,200	$ 2,106,593			$ 176,565	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,256,200	$ 2,106,593			$ 176,565	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 37,072	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 48,945	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,873	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 24,945	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 36,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	35,511	9
1999	36,019	10
2000	37,072	11
2001	36,945	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL MINUS $12,000 PREPAID

THE PAYMENT ON LINE 2 APPLIES TO 100% OF 2001 TAX BILL AND $12,000 TOWARDS 2002'S BILL

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF PONTIAC COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMBER 0043968

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-27-255-001	NURSING HOME	$ 36,945.08	$ 36,945.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,945.08	$ 36,945.08

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,600 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	85		1998	1961	$ 1,438,473	$ 52,308	27.5	$ 52,308	$	$ 228,847	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS - PURCHASE ALLOCATION (PROP)			1998	97,058	6,471	27.5	6,471		28,310	9
10	WATER HEATERS & PLUMBING (PROP)			1999	14,502	527	27.5	527		1,866	10
11	BOILER & A/C (PROP)			1999	14,240	518	27.5	518		1,834	11
12	ELECTRONIC DOOR LOCKS (PROP)			1999	3,974	145	27.5	145		513	12
13	FENCE (PROP)			1999	1,155	77	15	77		273	13
14	REMODELING ROOMS & BATHROOMS (PROP)			2000	47,944	1,743	27.5	1,743		4,430	14
15	AIR CONDITIONER (PROP)			2000	5,569	203	27.5	203		516	15
16	FIRE PANEL (PROP)			2000	2,730	99	27.5	99		738	16
17	FURNISHING			2000	2,839	497	7	497		1,598	17
18	WATER SOFTENER (PROP)			2001	4,013	146	27.5	146		225	18
19	CONDENSER (PROP)			2001	3,100	113	27.5	113		174	19
20	HEATER AND A/C UNITS (PROP)			2001	5,100	186	27.5	186		286	20
21	GREASE TRAP (PROP)			2001	1,300	47	27.5	47		73	21
22	3 DOORS (PROP)			2001	4,000	145	27.5	145		224	22
23	FENCE (PROP)			2001	2,564	171	15	171		263	23
24	SIDEWALK (PROP)			2001	1,850	123	15	123		190	24
25	CONCRETE WORK(PROP)			2002	3,938	132	15	132		132	25
26	FIRE ALARM SYSTEM			2002	40,476	797	27.5	797		797	26
27	RESIDENT SECURITY SYSTEM			2002	11,930	235	27.5	235		235	27
28	FIRE DOORS			2002	6,016	119	27.5	119		119	28
29	REMODELING 8 ROOMS			2002	46,151	909	27.5	909		909	29
30	SPRINKLER HEADS			2002	3,635	72	27.5	72		72	30
31	WATER LINE			2002	3,002	59	27.5	59		59	31
32	BACK FLOW PREVENTER			2002	3,300	65	27.5	65		65	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,768,859	$ 65,907		$ 65,907	$	$ 272,748	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 63,016	$ 8,150	$ 40,302	$ 32,152	10	$ 52,578	71
72	Current Year Purchases	11,089	4,879	554	(4,325)	10	554	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	340,000	33,294	34,000	706		150,906	74
75	TOTALS	$ 414,105	$ 46,323	$ 74,856	$ 28,533		$ 204,038	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN	1999 FORD ELD. VAN	1999	$ 43,112	$ 4,966	$ 8,622	$ 3,656	5	$ 30,177	76
77										77
78										78
79										79
80	TOTALS			$ 43,112	$ 4,966	$ 8,622	$ 3,656		$ 30,177	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,326,076	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,385	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 32,189	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 506,963	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,609 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 38,673	$		$ 38,673	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			16,619			16,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			69,959			69,959	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				37,368		37,368	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): MED SUPPLIES	39-8					160		160	13
14	TOTAL			$		$ 125,251	$ 37,528		$ 162,779	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC **#** 0043968 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,094	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	499,307		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,697		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	128,137		8
9	Other(specify): RE ESCROW	5,599		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 660,834	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,839		15
16	Equipment, at Historical Cost	117,217		16
17	Accumulated Depreciation (book methods)	(98,585)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,636		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,060)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): COMP SOFTWARE	11,450		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 33,497	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 694,331	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 211,466	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	452,829		29
30	Accrued Salaries Payable	40,582		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,289		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,945		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO DPA	9,958		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 747,069	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 747,069	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (52,738)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 694,331	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (71,701)	1
2	Restatements (describe):		2
3	POST CLOSING ENTRY(MANAGEMENT FEES)	(4,003)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (75,704)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	22,966	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 22,966	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (52,738)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,022,326	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,022,326	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	91,058	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 91,058	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT	627	28
28a	PRIOR YEAR ADJ	2,626	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,253	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,116,637	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	622,169	31
32	Health Care	1,200,406	32
33	General Administration	775,683	33
	B. Capital Expense		
34	Ownership	288,642	34
	C. Ancillary Expense		
35	Special Cost Centers	162,779	35
36	Provider Participation Fee	43,992	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,093,671	40
41	**Income before Income Taxes (line 30 minus line 40)****	22,966	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 22,966	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** **TAX RETURN IS CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,948	2,160	$ 54,352	$ 25.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,653	8,076	148,079	18.34	3
4	Licensed Practical Nurses	10,231	10,413	189,994	18.25	4
5	Nurse Aides & Orderlies	43,916	45,461	409,959	9.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,334	2,618	36,299	13.87	9
10	Activity Assistants	11,250	12,041	81,413	6.76	10
11	Social Service Workers	2,968	3,234	31,004	9.59	11
12	Dietician					12
13	Food Service Supervisor	2,025	2,187	23,654	10.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,047	18,227	132,138	7.25	15
16	Dishwashers					16
17	Maintenance Workers	1,600	1,685	21,517	12.77	17
18	Housekeepers	13,150	13,926	101,703	7.30	18
19	Laundry	5,896	6,526	55,152	8.45	19
20	Administrator	1,905	1,974	59,991	30.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	741	832	8,805	10.58	23
24	Clerical	4,583	5,133	66,554	12.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,002	2,251	23,449	10.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,249	136,744	$ 1,444,063 *	$ 10.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,521	1-3	35
36	Medical Director	O	5,500	9-3	36
37	Medical Records Consultant	N	1,160	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,223	10-3	39
40	Physical Therapy Consultant	L	650	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	848	11-3	44
45	Social Service Consultant	E	2,002	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,904		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 46,066	10-3	50
51	Licensed Practical Nurses		46,610	10-3	51
52	Nurse Aides		51,659	10-3	52
53	TOTAL (lines 50 - 52)		$ 144,335		53

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LORI STOGSDILL	ADMIN	0	$ 59,991
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,991

B. Administrative - Other

Description	Amount
ASTA HEALTH CARE COMPANY - MANAGEMENT FEES	$ 182,142
BARRY KIRCHENBAUM-MANAGEMENT FEES	15,000
KRUPNICK BOKOR-ACCOUNTING FEES	8,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 205,842

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		22,770
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 22,770

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,112
Unemployment Compensation Insurance	15,576
FICA Taxes	108,256
Employee Health Insurance	71,241
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,297
EMPLOYEE PHYSICAL EXAMS	720
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 235,202

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	8,939
Health Care Worker Background Check	713
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	23,635
TRUST/FRANCHISE/CONTRIB/ETC	1,721
LICENSES & PERMITS	3,438
DUES & SUBSCRIPTIONS	3,804
MGMT CO ALLOCATION	343
TRUST/FRANCHISE/CONTRIB/ETC	(1,721)
Less: Public Relations Expense	(0)
Non-allowable advertising	(23,635)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,637

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
EDUCATION AND SEMINAR	4,030
RELATED PARTY-SEMINARS	91
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,121

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT / DECORATING	6/00	$ 9,939	3	$	$ 1,657	$ 3,313	$ 3,313	$ 1,656	$	$	$	$
2	PAINT / DECORATING	6/01	2,075	3			346	692	692	345			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 12,014		$	$ 1,657	$ 3,659	$ 4,005	$ 2,348	$ 345	$	$	$

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC # 0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $ 4,336.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **43,992**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: ASTA CARE CENTER OF PONTIAC #0043968 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,521	
	REPAIRS & MAINTENANCE		181	
			0	6,702
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		586	
			0	586
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		18,816	
	ELECTRICITY		38,571	
	WATER		19,808	
	CABLE TV - LOBBY		1,552	
			0	78,747
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,830	
	PAINTING & DECORATING		499	
	BUILDING REPAIRS		5,687	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,349	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		555	
	EXTERMINATING SERVICE		1,421	
	FIRE SERVICE		8,042	
			0	
			0	
			0	26,383
7	**OTHER**			
	SCAVENGER		4,660	
	SECURITY SERVICE		921	5,581
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	144,335	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,404	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,160	
	PHARMACY CONSULTANT	XVIII B 39-2	2,223	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	100	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		3,641	
	DENTAL		1,414	154,277
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	650	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	650
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	848	
			0	848
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,844	
	SOCIAL WORKER	XVIII B 45-2	158	
			0	2,002
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF PONTIAC **#0043968** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	205,842	205,842
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,083	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	19,687	
			0	22,770
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	23,635	
	EMPLOYEE WANT ADS	XIX F	8,939	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	3,804	
	LICENSES & PERMITS	XIX F	3,838	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,721	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	713	42,650
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,661	
	EQUIPMENT REPAIR & MAINTENANCE		3,096	
	OUTSIDE CLERICAL SERVICES		775	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,983	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,920	
	MESSENGER SERVICE		288	
			0	26,723

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	108,256	
	UNEMPLOYMENT COMPENSATION	XIX D	15,576	
	WORKERS COMPENSATION INSURANC	XIX D	28,112	
	HOSPITALIZATION INSURANCE	XIX D	71,241	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,297	
	EMPLOYEE PHYSICAL EXAMS	XIX D	720	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	235,202
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	4,030	
	TRAVEL	XIX G	0	
			0	
			0	4,030
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,940	15,940
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		58,687	58,687
27	**OTHER**			
	BAD DEBTS	VI 24	12,886	
			0	12,886

GRAND TOTAL COLUMN 3 OTHER 906,006

ASTA CARE CENTER OF PONTIAC
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	112,801	PATIENT MEALS	83742
LESS SALES TAX	(2,194)	ADD EMPLOYEE MEALS	0
NET FOOD	110,607	TOTAL MEALS/YEAR	83742
TOTAL PATIENT CENSUS	27,914	NET FOOD	110607
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	83742
TOTAL PATIENT MEALS	83742	COST PER MEAL	1.32
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		